Modern Times Women's OB-GYN Assoc.;LLC

Idalia Talavera, MD & Rahil Malik MD

1200 N University Drive
Plantation, Fl 3322
954-791-3090 Office / 954-791-3166 Fax

Dear Patient:

Welcome to the practice of Dr. Idalia Talavera and Dr. Rahil Malik thank you for choosing us as your health care provider. To assist you on planning for your health care cost, we would like to inform you of our financial policies, which we request that you read and sign prior to any treatment.

INSURANCE / FINANCIAL RESPONSIBILITY: Our office is happy to accept you insurance at the time of your visit and we will file with your insurance carrier. Because insurance is a contract between you and your carrier we cannot become involved in disputes regarding claims, deductibles, co payments, non-covered charges, or other denial of payments. **It is part of our contractual agreement with any HMO or PPO policy to collect your co-payment.** We cannot extend any financial courtesy on these polices. If you have any questions regarding your insurance coverage, please contact your insurance representative. **We have the right to send your account to collections if your account balance becomes delinquent for more than 90 days. You will be responsible to pay any late and collection fees.**

REFERRALS: It is responsibility of the patient to obtain all referrals that are needed for any treatment given in this office. **It will be your responsibility to obtain and know that you need a referral to see a specialist** if that referral is not received in the office by the day of your appointment you may have to reschedule to see the Doctor another day. If you still want to be seen by the Doctor without a referral you understand that you will be bill for that day of service if your insurance doesn't pay.

MISSED APPOINTMENTS: Our office understands that there are circumstances that lead patients to miss appointments, at the same time, missed appointments take time away from other patients that need to see the doctor. Unless cancelled at least 24 hours in advance, **our policy is to charge a missed appointment fee of ($65.00)** regardless of insurance status. **Insurance do not cover this charge this will be your responsibility. Please help us serve you better by keeping scheduled appointments or rescheduling them in a timely manner.**

I HAVE READ, UNDERSTOOD AND AGREE WITH THIS FINANCIAL POLICY.

_____

Patient Name

_____ _____

Signature **Date**

NEW PATIENT WELCOME FORM

Came to see: ( ) Idalia Talavera, MD or ( ) Rahil Malik MD **Are you pregnant?** ( ) Yes ( ) No

Last Name: First name: Middle initial:

Date of Birth **Social Sec #** **Age:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street Address: **E-Mail** :

City: State: Zip

Home Phone: Work phone: Cell Phone:

Name of Employer: Occupation:

Emergency Contact: Phone#: Relation To Patient:

Primary Care Doctor: Phone Number: Fax

Whom May We Thank For Referring You?

Primary Language: English ☐ Spanish ☐ Creole ☐ Other ☐

Primary Insurance Name: **IF YOU ARE NOT THE MAIN INSURED PLEASE FILL OUT!**

Primary Insured Name/ ID#: Date of Birth:

Social Sec# Relationship with Patient

Employer:

Secondary Insurance Name: IF YOU ARE NOT THE MAIN INSURED PLEASE FILL OUT!

Primary insured Name: Date of Birth:

Social Sec# Relationship with Patient

Employer:

ASSIGMENT OF BENEFITS: **Pharmacy Number:**

CONSENT FOR TREATMENT: I, the undersigned, on behalf of the patient whose name appears above, hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the attending physician.
INSURANCE BENEFITS: I authorize payment of medical benefits to Idalia Talavera, M.D or Rahil Malik, MD. I also understand that all payments for medical care are my responsibility if my insurance denied payment unless prescribed by law.
AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any personal and medical information necessary to process my health insurance claim form.
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that I can request a copy of the practice's **NOTICE OF PRIVACY PRACTICES.** I understand that if I have any questions or complaints regarding my privacy rights that I may contact the person listed on brochure. I further understand that the practice will protect my information and will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way.

( ) Patient refused to sign **NOTICE OF PRIVACY PRACTICE** **( ) Patient was unable to sign because**

SIGNATURE **DATE**

✓ **Please complete for our files ; <u>Mark or describe all that apply</u> :**

Name: _____ **Date:** _____

DOB: _____

EMAIL:_____

Last menstrual period ___/____/_____

Last Pap smear ___/____/_____

Last Mammogram ___/____/_____

Last Colonoscopy ___/____/_____

Drug allergies? O NO O Yes _____

# of pregnancies _____# of deliveries _____

# of miscarriages _____# of abortions _____

Contraception:

O Tubal sterilization O IUD
O Pills O Menopausal
O DEPO O No sexually active
Other: _____

Medical History :

O Cancer; Describe _____
O Diabetes O High blood pressure
O Heart disease/ Stroke O Alcoholism
O Epilepsy O Drug abuse
O Depression O Ulcer
O Glaucoma O Fibroids
O Asthma O NONE
O Other Describe _____

Surgical History:

O Cesarean Section O Tubal sterilization
O Hysterectomy O Appendectomy
O Tonsillectomy O Breast augmentation
O Breast reduction
O Other Describe _____
O NONE

Are you experience:
☐ Depressive disorder ☐ Domestic violence

Is there anything else you would like to discuss with the doctor? _____

_____

_____

Family History:

O Cancer; Describe _____
O Diabetes O High blood pressure
O Heart disease/ Stroke O Alcoholism
O Epilepsy O Drug abuse
O Depression O Ulcer
O Glaucoma O Suicide attempt
O NONE **Other Describe** _____

Social History:

O Married O Single
O Separated O Divorce
Sexually active: **O Yes O NO** Alcohol use: **O Yes O NO**
O Smoking/ Per day _____ O Non smoker
Drug use: **O No**_____ **O Yes**_____
O Follows diet
O Exercise: / Never / 2-3 times week / daily
O Religious objections to blood transfusion
Other: _____

Review of Systems:

<u>General</u>: O weight gain O weight loss

O tiredness O Insomnia O Hot flushes

<u>Respiratory</u>: O Short of breath O Coughing

Other:_____

<u>Neuro-Muscular</u>: O Back pain O Joint pain

O Headaches Other: _____

Gastrointestinal: O Nauseas O Vomiting

O Diarrhea O Heartburn O Constipation

O Decrease or loss of appetite O Gas or bloating

<u>Genitourinary</u>: O Fecal Incontinence

O Blood in the urine O Pelvic pain

O Pain with intercourse O Painful periods

O Excessive menstrual flow O Painful Urination

O Urinary incontinence O Frequent urination

Other: _____

Signature: _____

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CONSENT FOR PELVIC EXAM

Dear Patient:

Effective July 1, 2020, Florida law requires a written consent to be obtained from the patient in order to perform critical components of your health examination and that includes the female pelvic exam.

This bill (s. 456.51, F.S.,) requires that a health care practitioner must have the written consent of a patient or a patient's legal representative to perform a pelvic examination.

In certain conditions, a health care practitioner may conduct a pelvic examination without written consent if:

- A court orders the performance of the examination for the collection of evidence;
- The examination is immediately necessary to avert a serious risk of imminent, substantial, and irreversible physical impairment of a major bodily function; or
- The examination is indicated in the standard care for a procedure that the patient has consented to.

By signing this document, you are permitting us to perform all components of your routine physical exam including pelvic exam (see below) in an office or hospital setting.

Pelvic Exam: "The series of tasks that comprise an examination of: the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation."

You may withdraw this written consent at any time by providing a written notice.

_____
Name

Date: _____

_____
Signature

Notice of Privacy Practices

Modern Times Women's OB-GYN Associates

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

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Office: 954-791-3090

Attn: Compliance Contact

Please sign the accompanying "Acknowledgement" form

2020

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Dear Patient:

We now offer our patients the only FDA-approved high-risk HPV test. This new test is a highly sensitive viral test used in conjunction with a Pap test for cervical cancer screening in women aged 30 and older. Persistent infection with high-risk human papillomavirus (HPV) is the primary cause of cervical cancer. A few important things to know about HPV and cervical cancer screening:

• Most women will have HPV at some point during their lives but very few will develop cervical cancer.

• Cervical cancer develops if an HPV infection persists for many years.

• The Pap test looks for abnormal cell changes on the cervix that occur as a result of a persistent high- risk HPV infection. The HPV test looks for an HPV infection.

• When used together, these tests can show with nearly IOO% certainty that you do not have cervical disease. Women who test negative for high-risk HPV, and have a normal Pap test, have virtually no risk of developing cervical cancer before their next scheduled visit.

• Knowing your HPV status helps you and your provider determine how often you should be screened. Early detection of pre-cancerous cell changes is the key to preventing cervical cancer.

• Your HPV status is not a reliable indicator of you or your partner's sexual behavior. HPV can lie dormant in cervical cells for many years before becoming an active infection.

Most insurance companies cover the high-risk HPV test when used with a Pap test for cervical cancer screening of women 30 or older. However, the individual benefits you or your employer purchased may or may not cover the test. If the test is not paid for by your insurance company, you will receive a bill from the laboratory. If you ask your provider for the approximate cost of the HPV test they will tell you **the price may range from $ 95 to $155 but most insurance companies cover the HPV test these days.**

☐ I have read the above information and **AGREE** to have the HPV test with my Pap test. I also agree to pay for the HPV test should my insurance not cover the cost.

☐ I have read the above information and **DO NOT** wish to have the HPV test at this time.

X _____ Date: _____
Patient Signature

_____
Patient Name (please write legibly)